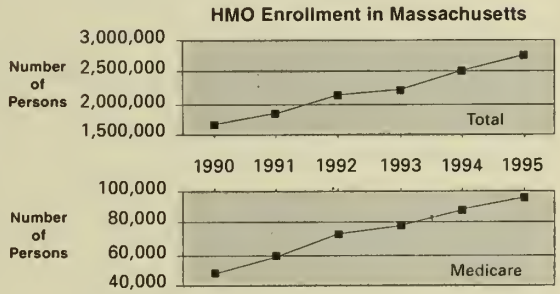
Healthpoint

Information from the Massachusetts Rate Setting Commission

MASSACHUSETTS SENIORS BEGIN TO CHOOSE MANAGED CARE

Managed care is a familiar concept; today it is taken for granted as a viable option for providing quality, comprehensive care in a cost-effective manner for working-age people and their dependents. Now, the managed care market for seniors is heating up. Several managed care companies in eastern and central Massachusetts have joined Fallon Community Health Plan, with its long-standing service to seniors, in competing for Medicare beneficiaries.

Massachusetts is one of the leading states in this growing area of health coverage. Ninety-seven thousand (12 percent) of the Commonwealth's Medicare beneficiaries were enrolled in Health Maintenance Organizations (HMOs) as of December 1995, which is double the level five years earlier. This publication discusses some reasons for the rapid increase and identifies a number of policy issues.



Medicare is the nation's health insurance program for 37 million aged and disabled persons. Medicare covers hospital, physician and other acute care services. Total federal outlays are projected to be $181 billion in fiscal year 1995. Part A is the hospital insurance portion and requires no premium. Part B, which is optional, covers home health care and 80 percent of the cost (after a $100 deductible) of physician and other services for a monthly premium of $46.10. Parts A and B both require deductibles and copayments. The rapid expansion of managed care in Medicare coincides with the national policy debate over the future direction of the Medicare program. HMOs are developing products and entering the market in response to the likelihood that Medicare may soon be transformed into a program that provides its beneficiaries many choices of how to receive and finance care, from comprehensive managed care to catastrophic coverage coupled with a medical savings account. At the same time, in an effort to control Medicare costs, the Health Care Financing Administration (HCFA) has sought to enroll Medicare beneficiaries in HMOs and other types of managed care plans.

Healthpoint

Information from the Massachusetts Rate Setting Commission

**Massachusetts
Rate Setting Commission**

**Two Boylston Street
Boston, MA 02116
(617) 451-5330**

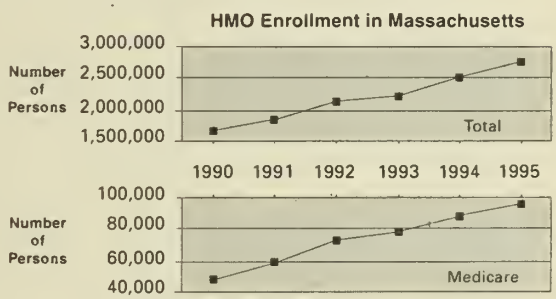
**Barbara Erban Weinstein
Chairman
Louis I. Freedman
Commissioner
Margaret Long Randle
Commissioner**

Vol. 1 No. 1 March 1996

MASSACHUSETTS SENIORS BEGIN TO CHOOSE MANAGED CARE

Managed care is a familiar concept; today it is taken for granted as a viable option for providing quality, comprehensive care in a cost-effective manner for working-age people and their dependents. Now, the managed care market for seniors is heating up. Several managed care companies in eastern and central Massachusetts have joined Fallon Community Health Plan, with its long-standing service to seniors, in competing for Medicare beneficiaries.

Massachusetts is one of the leading states in this growing area of health coverage. Ninety-seven thousand (12 percent) of the Commonwealth's Medicare beneficiaries were enrolled in Health Maintenance Organizations (HMOs) as of December 1995, which is double the level five years earlier. This publication discusses some reasons for the rapid increase and identifies a number of policy issues.



Medicare is the nation's health insurance program for 37 million aged and disabled persons. Medicare covers hospital, physician and other acute care services. Total federal outlays are projected to be $181 billion in fiscal year 1995. Part A is the hospital insurance portion and requires no premium. Part B, which is optional, covers home health care and 80 percent of the cost (after a $100 deductible) of physician and other services for a monthly premium of $46.10. Parts A and B both require deductibles and copayments.

The rapid expansion of managed care in Medicare coincides with the national policy debate over the future direction of the Medicare program. HMOs are developing products and entering the market in response to the likelihood that Medicare may soon be transformed into a program that provides its beneficiaries many choices of how to receive and finance care, from comprehensive managed care to catastrophic coverage coupled with a medical savings account. At the same time, in an effort to control Medicare costs, the Health Care Financing Administration (HCFA) has sought to enroll Medicare beneficiaries in HMOs and other types of managed care plans.

What is *Healthpoint*?

This is the first edition of a new quarterly publication combining the data and analytic resources of the Massachusetts Rate Setting Commission. Each *Healthpoint* will update trends of general interest and present a treatment of a health policy issue of current importance to policy makers in the Commonwealth. We would like to know what you would like to know. Please send your comments and suggestions for future policy topics to the Rate Setting Commission's Office of Communications: (617) 451-5310 (voice) or (617) 451-1878 (fax).

A majority of HMOs have "risk contracts." For each enrollee, HCFA pays the HMO a fixed monthly payment equal to 95 percent of the average Medicare fee-for-service (FFS) cost per capita in the enrollee's county. The HMO must provide, at a minimum, all services a Medicare beneficiary would receive while in the FFS system.

The Growing Popularity of Medicare HMOs

Managed care plans for the elderly have been available since 1985. Fallon CommunityHealth Plan in the Worcester area was one of the first HMOs to offer coverage. Seniors were often reluctant to join because of an unwillingness to give up long-standing relationships with their doctors. These concerns have not disappeared. What has changed recently to boost HMO enrollment among seniors are, first, the increasing attractiveness of managed care; second, encroaching financial concerns of seniors; and, third, the fact that HMOs are now marketing directly to seniors in an effort to expand market share.

Medicare HMO Contracts as of December 1995

	U.S.	Mass.
Number of Plans	293	13*
Persons Enrolled in HMOs (1,000s)	3,809	97
Total Medicare Enrollment (1,000s)	37,000	843

*Blue Cross Blue Shield of Mass. launched a new product January

Attractiveness. Primary care physicians have been contracting with HMOs in increasing numbers. As this happens, the option to join an HMO becomes more attractive to the physicians' elderly patients. Also, physicians can highlight for their patients the advantages of a managed approach to health care: more integrated care for those who need it most, primary and preventive services, and the removal of some barriers to care that exist in the fragmented FFS Medicare system.

Financial. In addition to Medicare Part A and Part B, many seniors purchase private supplemental insurance known as Medigap to cover the service gaps of existing fee-for-service coverage, such as prescription drugs, copayments and additional hospital care. Of the 843,000 Medicare beneficiaries in Massachusetts, approximately 300,000 purchase Medigap insurance, at an average annual cost of $2,000. Even with Medigap, many beneficiaries have high out-of-pocket costs, including coinsurance, deductibles, and a Part B premium of $46.10 per month. HMOs, on the other hand, offer a benefit package comparable to Medicare, plus additional benefits such as prescription drugs, vision and dental care not offered by traditional Medicare, with costs ranging from no additional premium (for most plans with no drug benefit) to $111 per month, with most plans requiring no deductibles or coinsurance. The national average Medicare HMO premium is $21 per month. A December 1995 study from the Massachusetts Office of Consumer Affairs reports that seniors who switch to a Medicare HMO can save up to 75 percent of their current total health expenditures. If current Medicare reform proposals include increased out-of-pocket costs for FFS beneficiaries, the financial advantage of HMOs would be enhanced.

Marketing. Some critics suggest that HMOs are able to provide comprehensive benefits at low costs because HMOs target younger, healthier seniors who require less care. They claim HMOs, though legally required to enroll all applicants who are eligible for Medicare Part A and Part B (except for those beneficiaries with end-stage renal disease and hospice patients), have in practice been marketing to a younger and healthier group of seniors. A General Accounting Office (GAO) report in November 1995 suggests that care for these seniors costs much less than the average Medi-

care beneficiary in FFS, a gap which has generated profits for the industry. HCFA requires that if revenues exceed a plan's cost by more than a specified allowance, plans are required to refund the savings either by increasing benefits or reducing premiums. There is little indication of the extent to which this rule has been enforced.

Policy Issues

Nearly 100,000, or 12 percent, of seniors in Massachusetts receive their medical care through HMOs, with numbers growing by 3,000 to 4,000 a month. (HMO enrollment for the entire Massachusetts population now exceeds 40 percent.) The Medicare beneficiaries remaining in traditional FFS represent a substantial potential market for managed care plans trying to expand. As the market continues to grow, state policy makers should understand how managed care might succeed or fail to meet the health needs of the elderly. A starting point may be to consider the following policy questions.

Will favorable selection occur and what will be the impact on costs? HMOs may recruit healthier Medicare beneficiaries, leaving a sicker and more costly group in the FFS sector. This could increase average FFS costs and subsequently Medigap insurance premiums, restricting access for those left in the FFS sector unable to afford the increases. A GAO report and a study by the Prospective Payment Review Commission support the hypothesis that the current reimbursement methodology overestimates the actual costs of HMO enrollees had they remained in FFS. An internal Congressional Budget Office memorandum concludes that, because of favorable selection, "Medicare's costs are likely to increase for each fee-for-service enrollee who switches to an HMO."

How will Medicaid expenditures be affected? HMOs may also save money by relying more heavily on nursing homes and home health care rather than hospital stays. Medicare only pays in part for the first 100 days of institutional skilled nursing care. Medicaid, funded jointly by the state and federal governments, is the safety net for long-term care for the 65-plus population: nearly three-quarters of Massachusetts nursing home residents receive assistance from Medicaid. There is some concern that a financial incentive exists for HMOs to admit costly Medicare beneficiaries to nursing facilities, where Medicaid will soon cover the costs of care.

What quality and satisfaction of care issues are there? Of particular interest is how well managed care is designed to meet the needs of the elderly who frequently have chronic, multiple conditions requiring different types of care from the under 65 population. Several studies show no negative effects on quality of care so far, and Medicare beneficiaries are generally satisfied with the care they receive. Nonetheless, there is currently a lack of benchmarks against which to measure quality; research to develop such benchmarks must catch up with the rapidly growing market before a thorough evaluation is possible.

What is the impact on service access? There is concern that access may be compromised to cut costs. Access may be inadequate for sicker beneficiaries, or for those in rural areas since managed care has mainly flourished in eastern and central Massachusetts, where capitation rates are higher. Access may also be restricted by HMOs limiting referrals to costly services and complex treatments.

What consumer protection issues should be considered? Beneficiaries have increasingly been asked to make choices, but the information needed to help make those choices has not kept pace. Currently, 13 plans offer managed care products for seniors in Massachusetts. The lack of information comparing HMO plans affects the ability of consumers to assess alternatives regarding differences in cost, benefits, copayments and deductibles.

What is the implication of upcoming federal changes? A number of policy discussions concerning Medicare HMOs are underway in Washington. There is a proposal to mitigate some of the regional variation in the reimbursement formula by sending more money to low-cost plans in the South and West and less to high-cost urban areas such as Boston. Second, Medicare officials are considering lowering by two percentage points an increase in HMO capitation payments that they proposed last October. Since many plans began marketing Medicare products based on an expectation of the higher increase, there is the potential that they will be unable to provide the level of benefits they are currently marketing. Questions may arise about how to protect the benefits of those already enrolled, regardless of what payment increase is finally approved. Lastly, there is concern that a Medicare reform plan may not provide sufficient funds to monitor the program to determine if quality and access standards are being met.

The enrollment of seniors in managed care is likely to continue in Massachusetts. The Massachusetts Division of Medical Assistance hopes to enroll beneficiaries eligible for both Medicare and Medicaid into managed care in the near future. As the numbers increase, current issues will continue to exist while others develop. Monitoring and evaluating the plans over time will determine how managed care can be a cost-efficient, high quality option for the health care needs of the elderly.

Further Reading

U.S. Government Publications

Medicare Managed Care: Growing Enrollment Adds Urgency to Fixing HMO Payment Problem. General Accounting Office, November 1995 (GAO/HEHS-96-[illegible])

Medicare: Increased HMO Oversight Could Improve Quality and Access to Care. General Accounting Office, August 1995 (GAO/HEHS-95-155)

Medicare Risk HMOs: Beneficiary Enrollment and Service Access Problems. Office of the Inspector General, April 1995 (OE-06-91-00731)

Other Sources

Michael [illegible] Langan and Joseph [illegible] Martingale, "Medicare Risk-Based HMOs: The Growing Market and Implications for Employers," Benefits Law Journal, [illegible] 8, No. 3, Autumn [illegible]

Harold [illegible] Luft, ed. *HMOs and the Elderly* (Ann Arbor: Health Administration Press, 1994)

Did you know?

Hospital Facts

	Massachusetts FY95 Data Submitted to Date	Massachusetts Comparable FY94 Data	Massachusetts FY94	Massachusetts FY93	Massachusetts FY90	U.S. FY93	California FY93
Number of Hospitals							
Acute	83	87	87	89	92	5,261	429
Non-Acute	53	54	54	54	65	862	64
Number of Acute Hospital Discharges (thousands)	730	760	823	881	895	30,748	3,052
Number of Acute Hospital Discharges/1,000 population	***	***	137	147	153	118	95
Number of Acute Hospital Days/1,000 population	***	***	766	873	1,046	831	542
Acute Hospital Length of Stay	5.39	5.64	5.68	5.97	6.82	7.02	5.69
Percent Inpatient Hospital Revenues	N/A	N/A	64%	67%	72%	73%	75%
Percent Outpatient Hospital Revenues	N/A	N/A	36%	33%	28%	27%	25%

Nursing Home Facts

	Massachusetts FY94	Massachusetts FY93	Massachusetts FY92	Massachusetts FY91	U.S. FY93	New York FY93
Number of Total Facilities	566	568	563	567	16,959	646
Number of Facilities with Medicaid Contracts	518	514	529	521	***	***
Number of Resident Days/population	2.97	2.93	3.06	3.03	2.31	2.11
Median Occupancy Rate	95.2	96.1	96.3	96.6	95	97.1
Operating Expense per Resident Day	$118.09	$108.27	$103.36	$99.82	$72.11	$132.45
Net Patient Revenue per Resident Day	$118.88	$110.65	$105.23	$100.28	$73.50	$133.28

Sources: Massachusetts Rate Setting Commission; *Hospital Statistics* 1994-95, American Hospital Association; The Guide to the Nursing Home Industry 1991-1993, 1994, 1995, HCIA Inc. and Arthur Andersen LLP; *Variation and Trends in Licensed Nursing Home Capacity in the States*, R. Dunahur et al., October 1993

Healthpoint

Information from the Massachusetts Rate Setting Commission

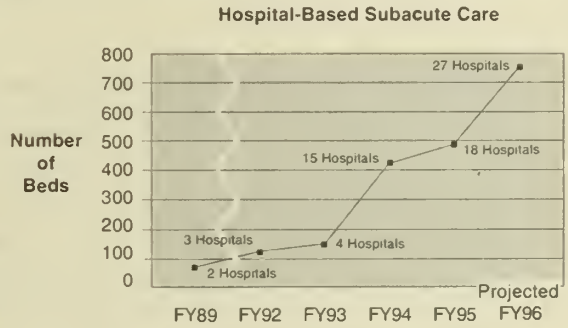
Massachusetts Rate Setting Commission

Two Boylston Street
Boston, MA 02116
(617) 451-5330

Vol. 1 No. 2 June 1996

COMPETITION HEATS UP: HOSPITAL SUBACUTE CARE UNITS ON THE RISE

As the competitive health care market drives the trend toward greater integration of care, hospital-based subacute care is expanding rapidly. In hospitals and other settings, the development of subacute care is motivated largely by a desire for cost control and by reimbursement incentives. Important questions—Is it good care? Does it save money? Under what circumstances?—are still unanswered. This issue of Healthpoint discusses the origin and evolution of subacute care and what incentives have drawn hospitals increasingly into the market. We also pose some of the policy questions—concerning where this care is best provided, to whom and at what cost—that warrant attention in this expanding segment of the health care system.



What is Subacute Care?

Subacute care—skilled, post-hospital care for patients with complex needs—grew in the 1980s as a response to the new Medicare Prospective Payment System, which encouraged hospitals to reduce lengths of stay for acute services. Subacute care provides patients a transition from the acute hospital to less intensive settings. Traditionally, such care has been delivered outside of acute hospitals—in rehabilitation hospitals, skilled nursing facilities, or by home health providers.

Recently, the concept of subacute care is evolving toward something more specialized, and acute hospitals are entering the market in increasing numbers. The prototypical subacute care is delivered in an organized program at a distinct site, and is centered on specific interventions, such as pain management, or on specific diseases, such as stroke. A program may also require special resources, such as more highly trained physicians and nurses than those found in a traditional post-acute facility, and employ specialized techniques like the use of interdisciplinary teams, case managers, critical pathway protocols, evaluation based on measured outcomes and continuous quality improvement.

Welcome to the second issue of *Healthpoint*.

This is the *second edition* of a new quarterly publication commissioned by the Massachusetts Rate Setting Commission. Each *Healthpoint* will update trends of general interest and present a treatment of a health policy issue of current importance to policy makers in the Commonwealth. We would like to know what you would like to know. Please send your comments and suggestions for future policy topics to the Rate Setting Commission's Office of Communications: (617) 451-5310 (voice) or (617) 451-1878 (fax).

Some see these characteristics as representing the ideal, though few providers have thus far realized it. There remains, however, the potential for the "new" subacute care to bring added value to the health care system.

The Massachusetts Market for Hospital-Based Subacute Care

Currently in Massachusetts 18 acute hospitals report operating subacute care units within the hospital (others own freestanding subacute facilities). These in-hospital units account for 482 beds. An additional nine hospitals intend to open 276 more subacute care beds. (See the chart on page 1.)

Why have acute hospitals found subacute care increasingly attractive? A number of factors influence the trend.

Highest Volume Hospital-Based Skilled Nursing (Subacute) Units

Beverly (Beverly)
Symmes (Arlington)
Saints Memorial (Lowell)
Medical Center of Central Mass. (Worcester)
Deaconess (Boston)

Source: Mass. Rate Setting Commission RSC-403

Compensation for declining inpatient business. The number of inpatient days in Massachusetts acute hospitals has fallen since 1990 by over 30 percent. One strategy for using excess capacity and thereby shoring up revenues is to provide different levels of care. In 1995, the 18 hospital-based subacute units delivered 125,000 patient days of care, equivalent to 13 percent of their inpatient volume. The average length of stay in these units ranged from 11 to 24 days, and total charges for these services were approximately $83 million.

Managed care. The high penetration of managed care in the state and the anticipation of more managed care for Medicare patients (Medicare patients account for 89 percent of the care provided in hospital-based subacute care units) influences the proliferation of these units as well. As health plans move toward more inclusive payment arrangements such as capitation, hospitals make themselves more attractive contracting partners if they provide a full range of care within their own integrated systems. A hospital-based subacute unit is thus a marketing point for hospitals seeking contracts with managed care plans.

Medicare reimbursement. Hospital-based subacute units developed partly in response to the advent of the Medicare prospective payment system for inpatient care. Acute inpatient care is subject to preset payment amounts for each Medicare admission. This creates an incentive to shorten lengths of stay, which is made more feasible if transitional care is available. During the first two years of a subacute unit's operation Medicare reimburses a hospital (usually more generously) on a cost basis for stays up to 100 days following an inpatient stay of at least three days. In subsequent years, Medicare reimbursement is still cost-based, but subject to a yearly inflation limit.

The Health Care Finance Administration (HCFA) announced this year that only those subacute units with a state-approved Determination of Need (DoN) are eligible for cost-based reimbursement from Medicare for the first two years. Only some of the new hospital subacute beds have a DoN; the remainder have been purchased from nursing homes and therefore must make do with less generous reimbursement while competing with less costly facilities. There is excess capacity in the

system, reflected in the large number of beds approved but not yet licensed and in the below-maximum occupancy of skilled nursing facilities, and the Department of Public Health has issued a moratorium on further DoN for skilled nursing services. .

Nevertheless, Massachusetts hospitals still find a financial benefit to purchasing beds and opening subacute units in the face of declining inpatient revenue. This benefit may be short-lived, as more Medicare patients enroll in managed care. HMOs may choose to direct patients to less costly subacute care in freestanding nursing facilities, a viable alternative given the available capacity. In addition, the American Health Care Association is studying the feasibility of designing a prospective payment system, like that now in place for Medicare acute hospital admissions, for subacute care. The long-term picture for subacute care in hospitals may therefore not be so optimistic.

Cost-Effectiveness and Quality of Care Issues

A number of forces converge to make opening a subacute unit a logical choice for many acute hospitals. As Costs differ so dramatically across the different sites of care—$131 per day on average in freestanding nursing facilities versus $454 in hospital-based units—it is important to have a way to evaluate whether patients are receiving care in the right places and for the right reasons.

Few studies have been able to determine the cost-effectiveness of subacute care. One major study on the potential cost savings to the Medicare program (conducted by Abt Associates for the American Health Care Association) projected, under various policy options (for example, waiving the minimum hospital stay necessary for admittance to a subacute care program) a range of potential savings from $225 million to almost $9 billion. The study made several assumptions that may not be substantiated, though, so the potential for savings is still very unclear. More research is required on this issue.

Similarly, there is little information about the quality of subacute care at different sites where it is delivered. There have been attempts to measure quality using, for example, the Functional Independence Measure, a well-established measure of outcomes for rehabilitation patients. There are also various measures in development for complex medical patients. An experiment now underway in Illinois seeks to compare both the costs and the outcomes for patients treated in hospital-based versus freestanding subacute facilities. Illinois is studying whether its Medicaid program should create a separate reimbursement category for subacute care, and which setting is most appropriate for its delivery.

* * * *

Subacute care may become an area of intense competition among different types of providers—acute hospitals, chronic/rehabilitation hospitals, freestanding skilled nursing facilities and home health providers. For acute hospitals, whose inpatient business has been dropping steadily over the past several years, the introduction of hospital-based subacute units may be one way of gaining back revenue. The high concentration of managed care in the state, the incentives of the reimbursement system, and the formation of integrated delivery systems (originating, for the most part, in acute hospitals) have fostered the emergence of these units.

Given the various settings for the provision of subacute care, and the potential impact of this competition on some providers' financial viability, more information would be useful to answer broad policy questions of financing and delivery:

What is the relative cost-effectiveness of subacute care provided in different settings?

Cost analyses to date have concentrated on differences in cost per day or in direct resource consumption between acute and non-acute settings. Decision makers should also know the effect of subacute care on the cost of an entire episode of care, as well as the effect of subacute care on long term outcomes for patients.

In what circumstances is subacute care most appropriate for the patient?

Hospitals want to transfer patients they discharge from acute care to their own subacute units, even if their capacity is taxed and there are available beds in a nearby freestanding facility. Apart from these financial imperatives, more information is needed to determine for which types of patients subacute care is most beneficial, and in what setting. Do only certain types of patients benefit from the substitution of a subacute care stay for additional days in an acute hospital? Do some patients benefit more than others and why?

What is the most effective care?

Finally, as with other segments of the health care system, there is a need for reliable indicators of the quality of care, particularly in comparison to alternative treatments and settings. Patients, clinicians, payers and policy makers should all benefit from information on the relative value of the many options for this type of care.

Further Reading

1. [illegible] and Market Area Analysis [illegible] 1995)
2. [illegible] Modern Healthcare [illegible]
3. [illegible] Business & Health [illegible]
4. [illegible] Modern Healthcare (Apr [illegible] 1994)

Did you know?

Hospital Facts

	Massachusetts FY96 Data Submitted to Date	Massachusetts Comparable FY95 Data	Massachusetts FY95	Massachusetts FY94	Massachusetts FY90	U.S. FY94	California FY94
Number of Hospitals							
Acute	83	83	83	87	92	5,229	427
Non-Acute	56	56	56	54	65	811	60
Number of Acute Hospital Discharges (thousands)	137	144	783	823	895	30,718	3,021
Number of Acute Hospital Discharges/1,000 population	***	***	131	137	153	118	94
Number of Acute Hospital Days/1,000 population	***	***	705	766	1,046	796	529
Acute Hospital Length of Stay	5.58	5.32	5.35	5.68	6.82	6.70	5.60
Percent Inpatient Hospital Revenues	N/A	N/A	60%	64%	72%	72%	75%
Percent Outpatient Hospital Revenues	N/A	N/A	40%	36%	28%	28%	25%

HMO Facts

	Massachusetts 1996	Massachusetts 1995	Massachusetts Change	U.S. 1996	U.S. 1995	U.S. Change
HMO Premium (large group, single, including R_x)	$ 178.07	$ 178.77	- 0.4%	$ 156.74	$ 161.68	- 3.1%
	1995	**1994**	**Change**	**1995**	**1994**	**Change**
Operating Margin	-2.9%	0.02%	- 3.1%	n/a	n/a	n/a
Required Revenue per Member per Month	$ 158.39	$ 157.39	0.6%	$ 131.98	$ 136.51	- 3.3%
Medical Cost per Member per Month	$ 138.91	$ 145.08	- 4.3%	$ 114.16	$ 117.37	- 2.7%
Total Members	2,467,177	2,279,725	8.2%	53,354,526	47,253,263	12.9%
Percentage of Population	40.6%	37.7%	7.6%	20.3%	18.1%	11.9%
Medicare Members	93,751	72,811	28.8%	n/a	n/a	n/a
Medicaid Members	87,627	94,007	- 6.8%	n/a	n/a	n/a

Sources: [illegible] MRSC Hospital Statistics 1994 [illegible] American Hospital Association; MRSC calculations based on Massachusetts Division of Insurance HMO Rate Filings, quarterly statements & NAIC Annual Statements; Milliman & Robertson 1994 & 1995 HMO [illegible] Publications 1994 & 1995 [illegible] Enrollment (U.S. figures); U.S. Bureau of the Census

Staff for th[illegible]

Benson Chin
Harry Lohr
Diane McKenzie
Carrie Norb[illegible]
Robert Seifert
Amy Simms

4625 28